STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation of #35640, 35735, 36126, and 36447, conducted on June 29 - July 2, 2015, at Cumberland Health Care and Rehabilitation, no deficiencies were cited in relation to #35735 and 36447.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157	F 157 **483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)** **SS=D** **Requirement:** A facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer McCleary	Administrator	7/17/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility investigation review, and interview, the facility failed to immediately investigate an allegation of abuse for 1(Resident #1) of 23 residents reviewed. The findings included: Review of a facility policy "Abuse" dated June 2014, revealed "...any report of actual or suspected abuse must be acted upon immediately...when an allegation or a suspicion of abuse/neglect/exploitation is made, the employee should immediately notify the Administrator or his/her designee..." Medical record review revealed Resident #1 was admitted to the facility on 10/16/14 with diagnoses including Legal Blindness, Congestive Heart Failure, Muscle Weakness, Diabetes Mellitus, Venous Insufficiency, and Orthopnea (shortness of breath when lying flat). Medical record review of an admission Minimum Data Set (MDS) dated 10/30/14 revealed the resident was cognitively intact. Review of a Grievance Record dated 4/13/15 documented "...daughter reported that someone had choked her mother. She stated it happened 2-3 days prior. Daughter stated her mother did not know who it was, but said her roommate saw the occurrence..."	F 157	**Corrective Action:** 1. Resident # 1 was discharged from the facility on 5/19/15. The CNA was in-serviced with specific instructions on 4/14/15 by the Administrator regarding the guidelines for reporting alleged abuse. 2. On 7/1/15, random residents were interviewed by the Activity Director for customer satisfaction with good reports. 3. (a) On 7/3/15 the Leadership Team was in-serviced by the Administrator regarding Abuse guidelines and reporting allegations timely according to facility policy. (b)The general staff was in-serviced on 7/17/15 by the Administrator regarding Abuse guidelines and reporting allegations of abuse timely according to facility policy. (c) The Administrator was in-serviced on 7/7/15 by the Regional Director of Operations regarding the facility policy on Abuse. (d) Random staff interviews will be conducted weekly by members of the Leadership Team regarding the guidelines and policy for allegations of abuse. The Leadership Team was in-serviced on 7/16/15 by the Administrator on conducting random staff interviews.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 Review of Certified Nurse Aide (CNA) #2's written statement dated 4/13/15 documented "...event: Thursday [4/10/15]...in the middle of me changing her...proceeded to say "why would she do that, she never acts like that," I asked what happened she said "she choked me up like that." I said who, she said [named Resident #2]..." Continued review revealed "...this event did not slip my mind but I continued on my hall w/o [without] saying anything - the next day it didn't register in my mind until later that after my shift was over..." Interview with the Administrator on 7/1/15 at 2:20 PM in the Administrator's office confirmed the CNA failed to report the allegation of abuse immediately per facility policy.	F 157	4. The Administrator and DON or designee will monitor for the random staff interviews weekly times 12, then monthly to ensure compliance. The findings will be reported to the QA Committee at least, quarterly. Completion Date 7/25/15	
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on facility policy review, facility investigation review, and interview, the facility failed to follow policies and procedures that prohibit mistreatment, neglect, and abuse of residents for 1(Resident #1) of 23 residents reviewed. The findings included:	F 224	F 224 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/ MISAPPROPRIATN SS=D REQUIREMENT: The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Corrective Action: 1. Resident # 1 was discharged from the facility on 5/19/15. The staff was in-serviced on 4/15/15 by the Administrator regarding the appropriate actions toward the accused based on the facility guidelines. 2. On 6/30/15 the Leadership Team was surveyed by the Administrator to ensure knowledge of appropriate actions to take when an allegation has been made.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 3 Review of a facility policy "Abuse" dated June 2014, revealed "...Accused Employees...any employee who is accused or suspected to have been responsible for afflicting abuse, neglect or misappropriation of patient property upon a patient shall be questioned regarding the alleged incident...accused employees, who comply with the interrogation proceedings, and who deny accusations of abuse, neglect or misappropriation of patient property shall be under immediate suspension..." Medical record review revealed Resident #1 was admitted to the facility on 10/16/14 with diagnoses including Legal Blindness, Congestive Heart Failure, Muscle Weakness, Diabetes Mellitus, Venous Insufficiency, and Orthopnea. Medical record review of an admission Minimum Data Set (MDS) dated 10/30/14 revealed the resident was cognitively intact. Medical record review of a Clinical Note dated 4/13/15 at 3:02 PM documented "...daughter came to this writer and stated a staff member had choked her mother. I ask when this had happened, daughter stated 2-3 days prior..." Review of a facility investigation dated 4/16/15 documented "...the patient told another CNA that the roommate and [had] " choked her up." She told a nurse that a CNA [Certified Nurse Aide] (CNA #1) choked her and at another point she stated to another nurse and the DON [Director of Nursing] that a nurse (Licensed Practical Nurse (LPN) #2) choked her..." Interview with CNA #1 on 6/30/15 at 9:09 AM in	F 224	3. (a) On 7/3/15 the Leadership Team was in-serviced and on 7/17/15 the staff was in-serviced by the Administrator regarding allegations of abuse and appropriate actions to take regarding the accused person to ensure the safety and wellbeing of the resident. (b) The Administrator was in-serviced on 7/7/15 by the Regional Director of Operations regarding the facility policy on Abuse. (c) Random staff interviews will be conducted weekly by members of the Leadership Team regarding the guidelines and policy for allegations of abuse. (d) The Leadership Team was in-serviced on 7/16/15 by the Administrator on conducting random staff interviews. 4. The Administrator and DON or designee, will monitor to ensure the random staff interviews are being conducted weekly times 12, then monthly to ensure compliance. The findings will be reported to the QA Committee at least, quarterly. Completion Date 7/25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 4 the activity room, when asked about the incident stated, "...during that time I worked 11 PM - 7 AM shift...I was aware of the incident but I did not choke the resident..." Continued interview revealed "...I was told not to go back in the room and care for her..." When asked if she was suspended pending the outcome of the investigation CNA #1 stated, "...no...I was not suspended..." Interview with the DON on 7/1/15 at 9:00 AM in the DON's office, when asked if the accused staff were suspended during the investigation stated, "...no, they were reassigned...not suspended..."	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS SS=D REQUIREMENT: The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on medical record review, occurrence investigation review, maintenance log review, observation and interview the facility failed to completely investigate and determine the root cause of the elopement of 1 (Resident #10) of 13 residents reviewed. The findings included: Medical record review revealed Resident #10 was admitted to the facility on 10/6/14 and discharged on 2/5/15 with diagnoses including Epilepsy, Anxiety, Psychosis, Alcohol Induced Dementia and Peripheral Vascular Disease. Review of the Quarterly Minimum Data Set (MDS) dated 1/10/15 documented the resident was severely cognitively impaired. He was ambulatory, wandered daily, and his wandering had worsened.	F 225	The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility will have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Corrective Action: 1. (a) On 2/5/15 immediately upon the resident being brought back in the building, a staff member was assigned to sit with Resident # 10 until the ambulance arrived to transport for discharged to acute in-patient psych hospital. (b) On 2/5/15 staff in-serviced by Administrator regarding Elopement Risk and Missing Resident procedures. (c)On 2/5/15 the Maintenance Director changed the codes to the Emergency Exit doors for added security.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 Medical record review of a Nurse's Event Note dated 2/5/15 at 5:54 PM documented "...Resident found walking outside the building...At around [2:25 PM] a nurse and a technician saw him walking outside the building...he almost got to the stop sign on...hwy..." Review of an Occurrence Investigation Statement from LPN #2 dated 2/5/15 documented "...Resident was seen approximately 225-230p (2:25-2:30 PM) outside facility walking towards the main street...walking outside on the street beside the facility..." Continued review of an Occurrence Investigation dated 2/5/15 revealed the "Causative Factor" for the event was left blank and the "Location of Occurrence" was left blank. Review of a statement written by the Administrator dated 2/5/15 regarding Resident #10's elopement documented "...it is believed pt [patient] exited the front door when some visitors left. No one heard the front door alarm that should have been triggered by the wander guard. Bracelet intact on pt. The system is tested weekly [without] indication of malfunction..." Review of the Secure Care Testing Log for Resident #10 documented a wander guard was in place and functioning from 10/7/14-2/5/15. The wander guard was checked every day Monday-Friday each week. Review of a Logbook Report with a Task Name: "...Resident Monitoring Systems: Check operation of door monitors and patient wandering system, daily if necessary ..." documented the Main Building doors/alarms were all checked on 1/26/15 and 2/3/15.	F 225	2. On 7/6/15 the Administrator and Maintenance Director rounded to perform wander guard bracelet door checks to ensure timing was set at less than 30 seconds, no irregularities were noted. 3. (a) On 7/3/15 and 7/17/19 staff was in-serviced by the Administrator regarding the process for thorough investigation of occurrences. (b) On 7/1/15, the keypad accessibility timing of the alarm for the double doors between the patient area and the service hall, was changed from 2 minutes to less than 30 seconds by the Maintenance Director. (c) On 7/13/15 the keypad for the same double door was armed with a wander guard sensor, by the Maintenance Director, so they will alarm should a resident with a device get close or attempt to exit through the doors. (d) Staff was in-serviced on 7/1/15 and 7/17/15, by the Administrator regarding the changes to the double doors. The Maintenance Director and Restorative Nurse or designee will monitor weekly to ensure all wander guard devices and door alarms are functioning properly. 4. The Administrator and DON or designee will monitor for compliance weekly times 8 then monthly and will report any findings quarterly to the QA Committee. Completion Date 7/25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 Interview and observation with the Maintenance Director on 7/1/15 at 7:25 AM by the facility entrance confirmed the main entrance door was the only door equipped to lock down and alarm in the event a resident with a wander guard device came near the door. The other outside doors of the facility were all equipped with an alarm and a keypad device. If a resident was to open one of those doors with or without a wander guard, an alarm would sound. The front entrance door and activity room doors were observed to be functioning when the Surveyor and the Maintenance Director toured and checked these doors. 12 residents with a wander guard device were observed and the devices were functioning properly when checked that morning by the Maintenance Director and the Surveyor. The Maintenance Director confirmed all exterior doors and alarms were checked weekly and he checked the residents with a wander guard device daily to ensure the wander guard was functioning properly. Interview and observation with LPN #2 on 7/1/15 at 1:30 PM at the nurse's station confirmed she had observed Resident #10 walking on the side of the street on 2/5/15 at approximately 2:30 PM. The resident was approximately 150 feet from the facility on the side road headed toward the main highway. Continued interview confirmed the wander guard in place on the resident's ankle and no alarm was sounding prior to LPN #2 exiting the facility. The LPN also stated when she asked the resident which door he had exited through, he told her the door by the room with the TV in it. Continued interview revealed the main dining room and the activity room were the only rooms with TV's in them and both had locked doors with	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8 alarms and keypads that exited to the outside of the facility. Continued interview with the LPN confirmed the route she and the CNA had taken on their way to a lunch break prior to seeing Resident #10 outside walking up the street. The double doors by the dining room led to the maintenance area, and was where the staff lockers and staff entrance were located. The double doors were swinging doors and had a keypad and alarm on them. The surveyor was able to slip behind the LPN and through the doors after the code to the keypad was punched. The hallway in the maintenance area led to an unlocked exterior door that staff used to enter, exit, and smoke on the receiving dock. It was on that dock that LPN #2 and CNA #3 noticed the resident walking on the side street to the left of the facility heading toward the main highway. Continued interview and observation revealed the LPN obtained a wander guard device and was able to enter the maintenance/staff locker area through the double doors with the wander guard and no alarm sounded. LPN #2 stated it was her belief this was how the resident exited the facility. Interview with CNA #3 on 7/1/15 at 2:00 PM at the nurse's station confirmed she and LPN #2 observed Resident #10 outside the facility walking up the side street toward the main highway on 2/5/15 at approximately 2:30 PM. The CNA reported running after the resident and she and LPN #2 assisted him back into the facility. The CNA confirmed there was no alarm sounding prior to her exiting out the staff door with the LPN in the maintenance area and observed the resident walking up the street. Observation on 7/1/15 at 3:04 PM with the Maintenance Director and the Administrator by	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9 the double doors leading to the maintenance area/staff entrance door revealed the doors were accessible for 2 minutes after the keypad was punched; then an alarm sounded and the doors would lock. During an interview on 7/1/15, at 4:10 PM in the conference room with the Administrator, the Surveyor notified the Administrator that the accessibility of 2 minutes after the keypad was punched on the double doors leading to the maintenance area was unacceptable and would have to be changed to accessibility of 30 seconds before the survey team left the facility on 7/1/15. Observation on 7/1/15 at 4:17 PM with the Maintenance Director and the Administrator by the double doors leading to the maintenance area/staff entrance door revealed the doors were accessible for 15 seconds after the keypad was punched; an alarm sounded and the doors were locked. Interview with the Administrator on 7/1/15 at 3:35 PM in the conference confirmed the facility entrance door and Resident #10's wander guard were functioning properly on the day the resident eloped (2/5/15). Continued interview confirmed staff and visitors did not hear any alarm prior to the resident exiting the facility. Continued interview confirmed the facility failed to check every door/alarm after the resident eloped; the Occurrence Investigation was incomplete; and the facility failed to determine exactly how the resident was able to elope when the documentation confirmed all doors, alarms and wander guards were functioning. The administrator stated, "The investigation was not complete, it could be more."	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, secure care testing log, nurse's event note, and interview, the facility failed to accurately assess 3 (Resident #10, 16, 20), and failed to monitor a wanderguard for 2 (Resident #10, 22) of 13 residents reviewed for elopement. The findings included: Review of the facility Elopement policy dated October 2014 revealed " ...In an attempt to reduce a patient's risk of elopement, each patient will have an Elopement Risk Assessment completed upon admission/readmission, quarterly, and with a significant change in status by a licensed nurse...Patients that trigger a 'YES'...will be identified as being at risk elopement. A wander guard device...will be implemented...If a wander guard device is used, the intervention...placed on the MAR [Medication Administration Record] to be checked each shift for placement...The Maintenance Director...will check wander guard devices weekly to ensure the device functions properly, with the findings documented on the Maintenance log..." Medical record review revealed Resident #10 was admitted to the facility on 10/6/14 and discharged on 2/5/15 with diagnoses including Epilepsy, Anxiety, Psychosis, Alcohol Induced Dementia and Peripheral Vascular Disease.	F 281	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS SS=D Requirement: The services provided or arranged by the facility must meet professional standards of quality. 1. (a) On 7/1/15 the Elopement Risk Assessments for Residents # 16 and 20 were revised by MDS Coordinators, to reflect current resident status. (b) On 7/2/15 the Treatment Administration record for resident # 22 was reviewed by the DON to ensure wander guard monitoring was present. (c) Resident # 10 was discharged 2/5/15. 2. (a) On 7/1/15 and audit was performed by DON, ADON, and MDS Coordinators, for Elopement Risk Assessments for all active residents to ensure accuracy and current information. (b) On 7/3/15 an audit of the Treatment Administration Record for all active residents with a wander guard device was conducted by the DON, ADON, and MDS Coordinators to ensure documentation of monitoring was present.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 11 Review of the Quarterly Minimum Data Set (MDS) dated 1/10/15 documented the resident was severely cognitively impaired. He was ambulatory, wandered daily, and his wandering had worsened. Review of the MAR and Treatment forms dated 10/2014, 11/2014, and 12/2014 revealed no documentation of the monitoring of a wander guard. Review of the Secure Care Testing Log for Resident #10 documented a wander guard was in place and functioning from 10/7/14-2/5/15. Medical record review of a Social Services note dated 10/9/14 at 5:21 PM documented "...Reported to writer that resident wanted to leave the facility..." Continued review of the Clinical Notes Report dated 10/9/14 at 6:17 PM documented "...resident seeking exits...wander guard put in place to left ankle..." Continued review of the Clinical Notes also documented multiple times of observing the resident seeking exits, wandering into other resident's rooms, pacing and requiring redirection from 10/9/14-2/5/15. Medical record review of an Elopement Risk Assessment dated 10/6/14 documented Resident #10 was not an elopement risk. Continued review revealed an Elopement Risk Assessment dated 1/13/15 documented the resident was not an elopement risk. Medical record review of the Clinical Notes Report dated 10/9/14 at 6:17 PM documented " ...resident seeking exits ...wander guard put in	F 281	3. (a) On 7/3/15, The DON, ADON, MDS Coordinators and Medical Records Nurse was in-serviced by the Administrator regarding the facility guidelines for updating resident assessments and documenting. (b) On 7/17/15 the nursing staff was in-serviced by the Administrator on the facility policy and guidelines as it relates to completing the Elopement Risk Assessment, monitoring and documentation. 4. The DON/ADON/Restorative Nurse or designee will monitor weekly times 8 then monthly and will report any findings to the QA Committee quarterly. Completion Date 7/25/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 12 place to left ankle ... " Medical record review of a physician's order dated 1/18/15 documented " ...Wander guard to (L) (left) ankle [and] check for placement QS [every shift]..." Review of a Nurse's Event Note dated 2/5/15 at 5:54 PM documented "...Resident found walking outside the building...At around [2:25 PM] a nurse and a technician saw him walking outside the building...he almost got to the stop sign on...hwy...They redirected back to the building..." Interview with RN #1 on 7/1/15 at 11:30 AM in the conference room, confirmed the Clinical Notes Report documented that a wander guard device was in place on the resident beginning 10/9/14 and that no monitoring of the device was documented for 10/2014, 11/2014 or 12/2014. Interview with LPN #5 on 7/2/15 at 10:50 AM in the conference room confirmed the Elopement Risk Assessments dated 10/6/14 and 1/13/15 were inaccurate for Resident #10 and he should have been assessed to be at high risk for elopement. Medical record review revealed Resident #16 was admitted to the facility on 8/2/13 with diagnoses including Dementia, Hypertension, Depression and Dysphagia. Medical record review of a Quarterly MDS dated 5/22/15, revealed Resident #16 was severely cognitively impaired and wandering behavior had not been exhibited. Medical record review of a Clinical Note dated	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 13 4/10/15 documented "...resident was found sitting at the front door of facility with his feet haning [hanging] outside. Resident made no statement when asked where he was trying to go..." Medical record review of a Physician's Telephone Order dated 4/10/15 documented "...apply wander guard to L [left] ankle & [and] monitor for placement every shift..." Medical record review of an Elopement Risk Assessment dated 5/22/15 documented the resident had no risk factors to indicate he was at risk for elopement. Interview with LPN #5 on 7/2/15 at 11:15 AM in the conference room, when asked if the Elopement Risk Assessment dated 5/22/15 was accurate, stated "...no...it's not..." Medical record review revealed Resident #20 was admitted to the facility on 11/14/06 with diagnoses including Chronic Obstructive Pulmonary Disease, Bipolar, Schizoaffective Disorder, Diabetes and Osteoarthritis. Review of the Quarterly MDS dated 5/8/15 documented the resident was severely cognitively impaired, and required assistance from 2 people to transfer into a wheel chair and to leave the unit. Medical record review of an Elopement Risk Assessment dated 5/20/15 revealed LPN #5 assessed Resident #20 not to be at risk for elopement. Continued review revealed an Elopement Risk Assessment dated 7/1/15 which documented the resident was a high risk for elopement.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 14 Interview with LPN #5 on 7/2/15 at 10:50 AM in the conference room, when asked if Resident #20 had a significant change between 5/20/15 and 7/1/15 stated, "No." Continued interview with the LPN revealed, when asked why the resident was now considered a high risk for elopement but was not considered to be an elopement risk on 5/20/15 stated, "I didn't think she needed a wander guard...but I had to justify her wander guard...I should have marked the assessment as 'No' does not wander without purpose..." Medical record review revealed Resident #22 was admitted to the facility on 6/12/15 with diagnoses including Dislocated Hip and Elbow, Rehabilitation, Diabetes Mellitus, Hypertension, Bipolar Disorder, Anxiety, and Poly Substance Abuse. Medical record review of a 5 day MDS dated 6/19/15, documented Resident #22 was cognitively intact and required extensive assistance of 1 for transfer, dressing, and bathing; assistive devices included walker and wheelchair; and the resident had not exhibited wandering behavior. Medical record review of a Elopement Risk Assessment dated 6/13/15, documented the resident was at high risk for elopement. Medical record review of a Physician's Telephone Order dated 6/13/15, documented "...wanderguard d/t [due to] elopement risk..." Medical record review of the June 2015 Treatment forms revealed no monitoring of wanderguard placement for Resident #22. Interview with the Administrator on 7/2/15, at 9:50	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. BUILDING _____ B. WING _____	C 07/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND HEALTH CARE AND REHABILITATION INC	4343 ASHLAND CITY HWY NASHVILLE, TN 37218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15 AM in the Administrator's office, when asked to review the June 2015 Treatment form documentation of monitoring of the wanderguard, stated "...no...looks like it was not monitored..."	F 281		